CLINICAL PREVENTIVE SERVICES EFFORTS: Process and Outcomes

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CHINLE EXPERIENCE

OBJECTIVES:

- Discuss the US Preventive Services Task Force Guidelines and other sources of guidelines and how they impact Indian Health Services
- Describe the process and outcomes of implementing top recommendations at the local level
- Describe how clinical preventive efforts are being monitored and tracked at the Chinle Service Unit

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY--AHRQ

- The lead Federal agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services

AHRQ Website Menu

- **A-Z Quick Menu**
- **Clinical Information Consumer Health**
- **Funding Opportunities**
- **Data & Surveys**
- **Research Findings**
- **Specific Populations**
- **Quality & Patient Safety**
- **Health IT**
- **Public Health Preparedness**
- **About AHRQ**
- Mission & Budget
- Strategic Plan
- Organization & Contacts
- Map & Directions
- Events & Announcements
- Job Vacancies

AHRQ PREVENTION GOALS

- Develop new knowledge about what preventive services are effective for patients
- Identify ways to improve the delivery of useful preventive services by providers
- Help healthcare systems incorporate knowledge into practice
- Provide stakeholders with options for improving preventive healthcare

US PREVENTIVE SERVICES TASK FORCE.

- Independent panel of experts in primary care and prevention that:
  - Evaluates the scientific evidence for a range of preventive services (i.e. counseling, screening and preventive medications)
  - Makes recommendations on whether a clinical preventive service should be routinely delivered.

USPSTF Guidelines

- One of the prevention programs in the Agency for Healthcare Research and Quality (AHRQ)

- Mission Statement:
  To improve the quality, safety, efficiency and effectiveness of health care for all Americans

PUT PREVENTION INTO PRACTICE

National program sponsored by AHRQ, to develop resources for clinicians, patients, and office systems to increase the delivery of USPSTF recommended preventive services in the primary care setting.

USPSTF PROVIDES ONGOING REVIEW: Makes Recommendations

- Most recent=3rd Edition compilation
- New recommendations put out as evidence is gathered
- Examples:
  - Abdominal Aortic Aneurysm screening—2005
  - Anemia, Iron Deficiency screening—1996
  - Colorectal Cancer screening—2002
  - Family violence screening—2004

AHRQ EVALUATION RATINGS

- A=Good evidence of improved important health outcomes, and benefits substantially outweigh the harm(s)
- B=Fair evidence of improved health outcome and benefits outweigh the harm(s)
- C=Fair evidence of improved health outcome, BUT benefits about equal harm(s)
- D=At least fair evidence of ineffectiveness or that harm outweighs benefit
- E=Insufficient evidence for or against, or evidence is conflicting, or risk/benefit undetermined

EXAMPLE: Timing of PAP Smears

- USPSTF 2nd Edition (1998)
  - First PAP at 18 y.o. and then annually
- Evidence Reviewed (1998—2003)
  - Epidemiology of cervical cancer and HPV
  - Clinical consequences
  - Accuracy and reliability of Screening Tests
  - Effectiveness of early detection
  - Potential harms of screening and treatment
  - Recommendations of others

Other sources considered by AHRQ

- American Cancer Society
- American Academy of Family Physicians
- American College of Obstetrics and Gynecology
- American College of Preventive Medicine
- Canadian Task Force on Preventive Health Care
- American Academy of Pediatrics

USPSTF 3rd Edition—2003

- Strongly recommends PAP smear screening for cervical cancer in women who have been sexually active and have a cervix: ***A Recommendation***
  - Indirect evidence suggests beginning screening within 3 years of onset of sexual activity and at least every 3 years
- Recommends against routine screening women over 65 y.o. if they have had adequate prior screening: ***D Recommendation***
- Insufficient evidence for or against routine use of HPV screening as adjunct. Awaiting ongoing trials: ***I Recommendation***

IHS GPRA/CRS INDICATOR

- 2002 Denominator: Female patients ages **18-70 w/o** history of hysterectomy who have had a PAP smear **in the year prior** to designated period
- 2006 Target: Maintain the proportion of female patients **ages 21-64 w/o** a documented history of hysterectomy who have had a PAP screen **within the previous three years** at the FY 2005 level

LOCAL PROCESS AND OUTCOMES

EVALUATION OF LOCAL PRACTICE

- 2000: CCHCF staff agreed on guidelines they wanted to pursue
- 2003: Directive to evaluate from Clinical Director
- 2004: CSU Strategic Plan included clinical strategy to: Use national clinical preventive services to focus and prioritize health care services
- 2005: Immunization subcommittee changed into the Clinical Preventive Services Committee

INITIAL CLINICAL PREVENTIVE SERVICES EVALUATION TABLE

- **RECOMMENDATIONS FOR SCREENING**
- For all women ages 50-75 years the following screening is recommended:
- Physical Exam:
- a. Blood pressure, height and weight
- b. Vision screen
- Pelvic exam
- Breast exam and teaching of self breast exam
- Heart and Lungs screening exam
- Mammogram annually starting at 50 years

- GPRA#J-2(dev), #3 for DM, J-4(dev) for BMI
- GPRA#7, WH pkg PAP,
- WH pkg, PFE code WH-BE
- GPRA#8 and WH pkg

COMPILED GRID

CLINICAL PREVENTIVE SERVICES GUIDELINES ADULT AGES 18—35 YEARS OLD 2002 User Population: 15392 2003 User Population: 15812 2004 User Population: 16494				7/26/05	
GUIDELINE	**COMMENTS OR QUALIFICATIONS**	**EVALUATION SOURCE(S)**	**REPORTED BY OR RESPONSIBLE FOR**	**REFERENCE OR EVIDENCE HP 2010 GOALS**	**UPDATED**
Recommendations for Universal Preventive Services					
Men and Women should complete a health guidance survey	Wellness Center type				
BP annually DM patients need at least 2 non-ER visit BP's annually		GPRA V81.1 screen for hypertension VS coded in RPMS		AHRQ=A recommendation IHS Standards of care for Type 2 DM HP 2010 12-9 less than 16% hypertension, HP 2010 12-10 50% controlled, HP 2010 12-12 95% with BP taken in last 2 years	2003 2003
BMI	2004 is GPRA baseline	GPRA for DM, 2004 GPRA everyone over 2 y.o. V77.8 screen for Obesity		AHRQ=B recommendation, screen and intensive counseling for obesity CDC HP 2010 19-1 60% at a healthy weight HP 2010 19-2 <16% Obese	BMI

USER POPULATION

- Active Clinical Population:
  - Reside in community
  - Alive
  - 2 visits in 3 years, at least one NOT ED
- User Population
  - Reside in community
  - Alive
- RPMS number seen

Standard Child Age Groups

- Birth to 2 years
- 3—10 years
- 11—17 years

- Sources of guidelines
  - AAP
  - USPSTF
  - AHCCCS
  - EPSDT
  - HEDIS
  - HP 2010 Goals
  - AMA GAPS for teens
  - ACIP for immunizations

Standard Adult Age Groups

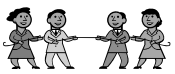
- 18—35 years
- 36—50 years
- 51—75 years
- 76 years +

- Sources of guidelines
  - USPSTF
  - American College of Obstetrics and Gynecology
  - CDC
  - HP 2010 Goals
  - HEDIS
  - AAFP
  - AIM

Guideline Categories

- Delivery of services
  - Periodicity
  - Anthropometric measures
- Screening
  - USPSTF and other guidelines
- Immunizations
- Health Guidance or Anticipatory Guidance or Patient Education or Counseling

Comments or Qualifications



- Place to note conflicts or differences in recommendations from equally authoritative groups or organizations: EXAMPLE
  - American Academy of Dentistry recommends first visit at 12 months of age
  - AZ EPSDT recommends fist visit at 3 years old
- Local decision based on needs of patients vs third party payor??

Example: GPRA vs USPSTF

- GPRA on IPV Screening
  - Female active patients 15-40 y.o. screened at any time during the report period
- USPSTF:
  - The USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse: **I Recommendation**

Example: SCREEN FOR ANEMIA

- AZ EPSDT recommends HCT at age 12 months
- AAP recommends HCT at either ages 9 or 12 months
- W.I.C. recommends HGB at ages 9 or 12 months, and between 12 and 24 months
- USPSTF recommends screening only high risk infants; otherwise, recommends using iron fortified food as prevention. **I RECOMMENDATION**

Example: Documenting DV Screen

- 2004 CCHCF reported rates on GPRA were 2.1%
- PCC+ had box with IPV screening
  - Providers misinterpreted the abbreviation
  - Coding didn't know how to code it

IPV **__Yes**
__No
__Within past year
__More than 1 year
__DV documentation completed

Example: Documenting DV Screen

- Changed box and prompts
  - Discussion with Coders and guidelines from IHS GPRA
  - Health Factor Box
  - Education of support and provider staff

HEALTH FACTORS

DV/IPV Exam 34	Tobacco Use	Alcohol Use	Drug Use V65.42
___NO/Negative	___None	___Cage 0/4 None	___Counseling
___Past (>1 year)	___Current smoker	___Cage 1/4	___No use
___Present (<1 year)	___Current Smokeless	___Cage 2/4	___Uses
___Refused screen	___Smoker in home	___Cage 3/4	
___Unable to screen		___Cage 4/4	

DV Screening Rates

- 2004 Screening rates 2.1%
- 2005 reported screening rates for CSU

42.0%

Evaluation Sources

- GPRA/CRS Indicators
- ICD-9 and CPT Codes
  - Example V77.1 Screen for Diabetes
- E&M codes
  - 99392 Health Supervision under one year
- Exam codes
  - Exam 34 documents DV/IPV screening
- PFE codes from IHS Protocols

REPORTED BY OR RESPONSIBLE FOR

- GPRA nationally has someone responsible for a specific indicator
- GPRA locally has a staff member responsible
- A few non-GPRA recommendations have responsible people

Date Recommendation was last UPDATED

- Screen for Nutritional Risk of Anemia
  - AHRQ last update 1996
    - I—recommendation
  - AAP policy statement 2003
- General depression and/or suicide risk screening
  - AHRQ last update 2004
    - I—recommendation

CLINICAL PREVENTIVE SERVICES COMMITTEE

POLICY

The Clinical Preventive Services Committee will identify, prioritize, and recommend the Clinical Preventive Services to be offered to all eligible beneficiaries. The committee will design implementation strategies, and monitor the effectiveness of the services provided. These services will support the elimination of health disparities as directed by the IHS Strategic Plan Objective 3.1.2& .3

CLINICAL PREVENTIVE SERVICES COMMITTEE

PURPOSE:

The committee is an advisory group of the health professions staff and serves as the organizational line of communication between the departments and clinical care sites. It is a policy recommending body to the health professions staff and the administration of the hospital on matters related to the provision of clinical preventive services.

IMMUNIZATIONS

- CPS Committee continues to monitor and advise on immunizations with participants:
  - Chief pharmacist
  - Director of Public Health
  - Preventive Services consultant
  - Director of Public Health Nursing
  - Department chair, Pediatrics
  - Adult medicine representative
  - Etc.

QUARTERLY IMMUNIZATION REPORT REVIEW

- Committee specifically reviews with PHN's
- Committee reviews Navajo Area comparisons to CSU
- Committee evaluates barriers to immunizations
- Committee recommends additional ways to increase immunization rates

PRIORITIZING PREVENTIVE SERVICES

- GPRA/CRS indicators
  - Immunizations
  - Diabetes
  - Screening
- Population specific or clinical issues
- Staff interest

GPRA/CRS

- First priority
- Analyze all aspects of the indicator and how the patient can be seen and provided the service

Example: MAMMOGRAMS

- GPRA: Maintain the proportion of eligible Female Patients who have had a mammography screening within the last 2 years
- USPSTF: B-RECOMMENDATION
  - Screening mammogram with or without clinical breast exam every 1-2 years for women age 40 and older (equivocal ages 40-49, better evidence over age 50 and older).
- Healthy People and IHS Goal 2010:
  - 70% of women over age 40 have a mammogram in last 2 years

Chinle Analysis: MAMMOGRAMS

- The usual
  - Women seen
  - Orders from Adult clinic and MCH
  - % show rates
- Mammograms by community of residence
  - Access issues
  - Geo-mapping

POPULATION SPECIFIC ISSUES

- TOBACCO
  - Navajo use of cigarettes is low
  - Cigarette use increasing in younger populations
  - Chewing tobacco higher
  - Prevention in 6-10, 11-17 y.o.'s
  - Better documentation of screening
- USPSTF A-RECOMMENDATION to counsel on cessation

OH BY THE WAY-----

- **Health Factor Box also improved**:
  - Tobacco screening documentation:
    - 2003 9.4%
    - 2004 29.1%
  - FAS/Alcohol screening documentation
    - 2003 1.8%
    - 2004 36.9%

STAFF INTEREST

Example: Osteoporosis Screening

- USPSTF: B-RECOMMENDATION for women age 60 and older if at risk, and all women over age 65
- CSU staff concerned about number of elders with fractures

STAFF REFERRAL TO CPS COMMITTEE

- Clinical Preventive Services Committee developed 2 year QI/QM project
  - Year 1—evaluate current status and provider education
  - Year 2—change process and evaluate cost effectiveness of current system; make recommendations to administration about best practice for service unit

Analysis: OSTEOPOROSIS SCREENING

- Number of Women age 65 and older
- Number with diagnosis
- Pharmacy query for number of women over age 60 on:
  - Alendronate
  - Calcitonin
- Who initiates consult to Contract Health
- Mechanism for getting screening done
  - Contract Health documentation
  - Clinically useful data hard to retrieve
- Tracking and follow up

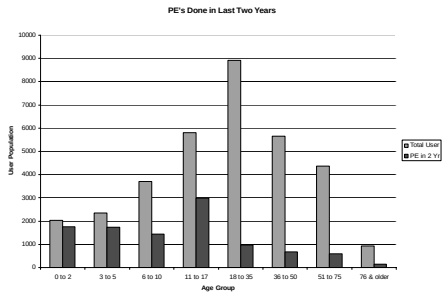
STRATEGIES FOR PROVIDING PREVENTIVE SERVICES

- Annual physical exams
- Clinical reminders
- Flow sheets
- Problem lists

User Population vs Resources

- User population by age
- Frequency of service, screening, counseling
- Staffing by age group
- Who can do which parts of the screening
- Creative data collection

SEMI-ANNUAL PHYSICAL EXAMS



CLINICAL REMINDERS

- PCC+ merge fields
  - Gender specific
    - Women:
      - Last PAP
      - Last Mammo
      - Last _____
  - Disease specific
    - Lipids
    - Blood pressure

EHR CLINICAL REMINDERS

- Pop-up technology coming
- NOT THERE YET
- Trial one indicator--SOON

Ihs-ehr.lnk

Examples: FLOW CHARTS

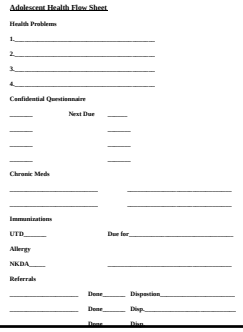
Diabetic Flow Chart:

•Case manager maintains chart

•Critical parts of care

- •HgbA1C
- •Foot Exam
- •Lipids
- •BP, etc

•Diabetes Registry



Adolescent Health Flow Sheet

Health Problems

1._____
2._____
3._____
4._____

Confidential Questionnaire

_____ **Next Due** _____
_____ _____
_____ _____
_____ _____

Chronic Meds

_____ _____
_____ _____

Immunizations

UTD_____ **Due for**_____

Allergy

NKDA____ _____

Referrals

_____ **Done**_____ **Disposition**_____
_____ **Done**_____ **Disp.**_____
Done **Disp.**

PROBLEM LISTS & HEALTH SUMMARIES

Issues with

- PCC+ Active Problem List
  - Most recent visit diagnoses
- Paper problem list
  - Multiple providers,
  - Don't keep up list
  - Consistency of what is important
- Health Summary
  - Too much data

PREVENTIVE SERIVCES GRID

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CHINLE SERVICE UNIT USES OF GRID

- Clinical departments use CPS-compiled grids
  - Priorities for visits
  - Development of Quality Improvement projects
- Administration uses CPS Committee to
  - Evaluate indicators
  - Recommend strategies for providing services

LEADERSHIP INITIATIVES

SUCCESS DEPENDS ON

- SYSTEMS PROBLEMS REQUIRE SYSTEMS SOLUTIONS
- Multiple disciplines meeting together
- Multiple disciplines learning to “speak” each others’ language
- Recognizing cultural assets and barriers
- PEER PRESSURE
- GPRA is part of everyone’s PAS

PREVENTION BELONGS TO EVERYONE